ARKANSAS DEPARTMENT OF HIGHER EDUCATION
114 EAST CAPITOL
LITTLE ROCK, AR 72201-3818
(501) 371-2058

ARKANSAS HEALTH EDUCATION GRANT (ARHEG) PROGRAM
FORGIVABLE LOAN FOR DENTISTRY

REQUEST FOR DEFERMENT

Please print or type in black ink only.

DATE: _____ **SSN** _____

NAME: _____

ADDRESS: _____

CITY/STATE/ZIPCODE: _____

PHONE: _____ **EMAIL**: _____

REASON FOR DEFERMENT: (Check one)

1. ____ **Continuing Education**: I am enrolled in a full-time course of graduate study in specialized field of dentistry at an accredited institution of higher education. If you chose this option, you must include the **Certification of Registrar** and return it to ADHE along with this form.

2. ____ **Unemployment:** I am seeking, but unable to find employment as a licensed dentist in Arkansas. If you chose this option, you will be required to show positive proof that you have made a valid effort to secure employment, i.e., list of names and dates of those contacted for employment. Any proof you provide to **ADHE** will be verified. **NOTE**: Unemployment Deferment cannot exceed 12 months.

4. ____ **Personal Health**: I am temporarily/permanently totally disabled as established by the signature of a licensed physician on the physician certification statement below. If you chose this option, you must include the **Certification of Physician** and return it to ADHE along with this form. **NOTE:** ADHE reserves the right to require a second opinion by an ADHE-approved physician. Unemployment Deferment cannot exceed three (3) years as established by the signature of a licensed physician on the deferment form provided by ADHE.

5. ____ **Family Health**: I am temporarily unable to secure employment due to the care of a spouse who is ill/disabled as established by the signature of a licensed physician on the physician certification statement below. If you chose this option, you must include the **Certification of Physician** and return it to ADHE along with this form. **NOTE:** ADHE

reserves the right to require a second opinion by an ADHE-approved physician. Unemployment Deferment cannot exceed twelve (12) months as established by the signature of a licensed physician on the deferment form provided by ADHE.

6. ____ **Military Obligation**: I perform or have performed active duty as a member of a uniformed service of the United States Military forces.

Uniformed Service Serial No. _____. Branch of Service _____.

NOTE: If you check this deferment option, you must provide a copy of your military orders with this form.

ADHE reserves the right to request any documentation it deems necessary to validate deferment claims. All deferments are subject to the approval of **ADHE.**

_____ _____

Signature of Borrower Date

FOR ADHE USE ONLY: Approved_____ Not Approved_____

If not approved, give reason here: _____

COMMENTS OR NOTES:

_____

_____

_____

_____

CERTIFICATION OF PHYSICIAN

NOTE: Must be signed in the presence of a commission notary public.

I _____ CERTIFY THAT THE
(Print Name of Physician)

ABOVE CLAIMED STATUS IS CORRECT FOR THE PERIOD OF _____ TO _____ AND I DECLARE UNDER PENALTY OF PERJURY, UNDER THE LAWS OF THE UNITED STATES OF AMERICA, THAT THE FOREGOING IS TRUE AND CORRECT.

_____ _____
Nature of Impairment Expected length of disability

_____
Signature of Physician

_____
Street Address City State Zip Code

_____ _____
Phone Number Date

STATEMENT OF NOTARY PUBLIC

STATE OF ARKANSAS COUNTY OF_____

Subscribed and sworn before me this _____ day of _____, 20_____

Signature of Notary Public: _____

My Commission Expires: _____ 20_____

AFFIX OFFICIAL SEAL OR STAMP

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CERTIFICATION OF REGISTRAR

NOTE: Must be signed in the presence of a commission notary public.

I, _____ certify that
(Print Name of Registrar)
_____ is enrolled for _____
(Name of Borrower)

Credit hours in _____
(Program of study)

At _____
(Name of Institution)

_____
Signature of Registrar

DATE_____

STATEMENT OF NOTARY PUBLIC

STATE OF ARKANSAS COUNTY OF_____

Subscribed and sworn before me this _____ day of _____, 20_____

Signature of Notary Public: _____

My Commission Expires: _____ 20____

AFFIX OFFICIAL SEAL OR STAMP